IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

June 26, 2006

Shauna Kraus, Administrator
Parke View Care & Rehabilitation Center
2303 Parke Avenue
Burley, ID 83318

Provider #: 135068

Dear Ms. Kraus:

On **June 1, 2006**, a Complaint Investigation was conducted at Parke View Care & Rehabilitation Center. Marcia Key, R.N. and Lisa Kaiser, R.N. conducted the complaint investigation. A total of 17 survey hours were required to investigate this complaint. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00001443**

ALLEGATION #1:

The complainant stated the identified resident fell from a Hoyer lift shortly after admission in March, 2006, due to mechanical malfunctioning. The facility continued to use the lift and subsequently the resident was involved in two additional Hoyer lift incidents.

FINDINGS:

The facility's incident and accident reports were reviewed for the time period of March through May 2006. There were no identified incidents of any residents falls in the facility due to mechanical lift malfunction. One incident and accident report documented that on April 21, 2006, the identified resident sustained a bump on the head after the mechanical lift malfunctioned. Interviews with the two certified nursing assistants (CNAs) involved revealed the lift suddenly jerked upwards and then down without any manipulation of the controls by either certified nursing assistant (CNA). This resulted in the resident landing abruptly in her wheelchair where she had just been positioned to be placed. After the resident landed in the wheelchair, the mechanical lift bar bumped her head. The resident sustained no apparent injury. The facility staff assessed the resident appropriately. The mechanical lift was immediately removed from the resident's room, maintenance was notified and the lift was removed

entirely from all patient care areas until repaired.

A second incident and accident report dated April, 25, 2006, documented the resident sustained a small skin tear to her elbow during transfer. The resident apparently moved her arm during the transfer, hitting her elbow on a control lever. The lift used for this transfer was a hydraulic lift as the mechanical lift was out for repairs. A staff member cleansed the wound and applied steri-strips to the area. No other injuries were identified.

The Administrator and Director of Nursing (DoN) were interviewed during the investigation. They stated there have been no resident falls from any lift devices. There were no other injuries in the facility due to mechanical malfunction of a lift device.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the family was not notified following an incident involving a lift device and the identified resident.

FINDINGS:

Review of the incident and accidents from March through May 2006, identified two incidents involving this resident. Each report documented an attempt was made to contact a family member in a timely manner.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that after a staff member cleansed and dressed a skin tear to the resident's right elbow, the staff member placed bloody napkins and towels in the resident's sink where a visitor observed them later.

FINDINGS:

The Unit Manager licensed nurse was interviewed during the investigation. She stated the resident's skin tear was not to an extent that caused bleeding.

The Director of Nursing and a licensed nurse were interviewed regarding infection control policies and procedures relating to disposal of contaminated items. Each stated it was not an acceptable practice to place contaminated items in a resident's sink. Contaminated items were to be placed in the appropriate bio-hazard bags for disposal.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the incidents involving the identified resident and lift devices were due to staff error and inadequate certified nursing assistant training.

FINDINGS:

Upon review of the two incident and accidents reports, it was determined the two were not caused by staff error.

Interviews were conducted with the Administrator, Director of Nursing and random certified nursing assistants. Each stated certified nursing assistants receive training on operating lift devices upon hire, when a new device is introduced into the facility, and at regular intervals as needed. Mentor certified nursing assistants make random observations during direct resident care to ensure that lifts are being used properly.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated the identified resident had a Foley Catheter placed while at the facility. The Foley Catheter began to leak and staff did nothing to intervene for over a week. The resident developed a urinary tract infection during this time period. The resident's catheter bag was often more than half full and upon request to empty, the staff did not comply.

FINDINGS:

The resident was admitted to the facility on March 29, 2006, with an indwelling Foley Catheter. Review of the record documented long-term use of an indwelling Foley Catheter. The record indicated the resident developed a urinary tract infection at about the time the catheter was found to be leaking. It cannot be confirmed that the resident developed the urinary tract infection because the catheter was leaking or if the leaking was due to the infection. The nursing notes identified two separate days in April 2006 when the catheter leaked and staff appropriately intervened by placing a new Foley Catheter. There is no documented evidence that the leaking occurred for the time period as identified in the complaint.

During random observations in the facility, multiple residents were observed in common areas in the facility with privacy bags over the Foley Catheter bag. Foley Catheter bags are equipped with anti-reflux valves to prevent backflow of urine from the bag into the bladder thus causing infection. Review of the

intakes and output records identified the resident's catheter bag was emptied on each shift.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated the resident's barrier pad on top of the bed sheets was not changed by staff after it was observed to be stained with stool.

FINDINGS:

Upon entering the facility, all units were toured. Each room entered by the surveyors was observed to be clean, neat, and without urine or feces odor. Bed linens were observed to be clean.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated that over-the-counter eye drops brought in by family members was misplaced by staff.

FINDINGS:

Two licensed nurses were interviewed during the investigation. One licensed nurse who worked on the Medicare unit stated a family member brought in an over-the-counter eye drop bottle which appeared to have been previously opened. The licensed nurse stated she informed the individual that this item could not be used without first obtaining an order from the physician. The licensed nurse stated she placed the item in a bag with the resident's name and secured it in the medication room. Once the order was received, the resident was in another unit and the family member brought in another bottle of eye drops. The Unit Manager licensed nurse was interviewed, she checked the medication cart for the surveyor and identified that the over-the-counter eye drops are currently being supplied by family members not the pharmacy.

Facility grievances were reviewed for the time period of March through May 2006. There were no grievances documenting a problem with missing resident medication which was supplied by family.

The Administrator was interviewed and stated she had received no written or verbal grievances regarding missing medication which was supplied by a family member.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The complainant stated the facility did not administer the over-the-counter eye drops in accordance with the physician's order.

FINDINGS:

The resident's record was reviewed and documentation revealed over-the-counter eye drops were to be given on an as-needed basis not on a set time schedule.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The complainant stated the facility did not transport the resident to a scheduled eye appointment because there was no one to assist the resident with transferring at the physician's office. The appointment was subsequently cancelled.

FINDINGS:

An interview was conducted with the certified nursing assistant who transported the resident. She stated she had contacted the physician's office prior to the scheduled appointment to alert them the resident required a mechanical device to transfer from wheelchair to the examination chair. She stated the receptionist consulted with someone in the physician's office regarding this matter and reported back that the appointment would need to be rescheduled at a later date when the resident could be safely transferred.

The resident's record was reviewed. The resident did not require a dosage change to prescription eye drops secondary to missing an appointment. The record revealed the resident received all prescribed eye drops as ordered by the physician.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #10:

a. The complainant stated the resident was left on a bedpan overnight.
b. On that same night, the resident did not have her C-Pap machine applied at bedtime.

FINDINGS:

a. During the investigation, it was identified the facility had thoroughly investigated an allegation that the resident was left on a bedpan overnight. All staff involved during that time frame was

interviewed. The night staff stated the resident did not require the use of the bedpan throughout that night. The day-shift shower aide stated that when she got the resident up the following morning, she was not laying on a bedpan. Two day shift certified nursing assistants stated they put the resident on a bedpan that morning. They checked on her after approximately ten minutes and the resident indicated she was not finished and wanted to remain on the bedpan. The certified nursing assistants stated they returned to the resident's room 30 to 45 minutes later to remove the resident from the bedpan. The investigation report documented licensed staff were unaware of pain or injury from this apparent incident until the resident returned from a doctor's appointment later in the day. The resident informed the doctor, in the presence of a family member, that she had been on the bedpan overnight.

Upon return to the facility, a family member informed staff of the apparent incident. The Unit Manager and another licensed nurse immediately assessed the resident's skin in the buttock region. They identified a mark approximately one-eighth of a centimeter wide in the shape of a horse shoe encircling the resident's buttock region. The area blanched which indicated good blood return to the site and there was no identified skin breakdown.

The resident's record was reviewed and the documentation revealed the resident had not made any complaints of pain to the staff that day. The record documented previous occasions that the resident requested to be left on the bed pan for an extended period of time until she had a bowel movement.

b. The investigation report revealed the licensed nurse on the night shift relayed, via taped report, that the resident had declined to wear her C-Pap the previous night.

The resident's record revealed other occasions when the resident declined to wear her C-Pap at bedtime.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Marcia Key

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj